PERFORMANCE AUDIT REPORT

of the

SPED and Expanded SPED Programs

October 26, 2001

Report No. 3018

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October 26, 2001

Honorable John Hoeven, Governor
Members of the North Dakota Legislative Assembly

Transmitted herewith is the performance audit report on aspects of the Service Payments for the Elderly and Disabled (SPED) and Expanded SPED programs. This report contains the results of our study of the SPED and Expanded SPED programs, along with the results of a review performed by an independent consultant. We specifically reviewed the procedures used to make payments to Qualified Service Providers, the procedures related to case management services, and the procedures for determining client and Qualified Service Provider eligibility. In conjunction with our office, the independent consultant reviewed client eligibility and the case management services provided for selected cases.

The audit was conducted under the authority of Chapter 54-10 of the North Dakota Century Code. Included in the report are the goals and scope, findings and recommendations, conclusions, and the responses from the Department of Human Services.

We want to extend our appreciation to the management and staff of the Department of Human Services and the Aging Services Division for their excellent and timely cooperation during this audit.

Sincerely,

Robert R. Peterson
State Auditor

Executive Summary

Purpose and Authority of the Audit

Based on the results of a risk analysis performed on all programs within the Department of Human Services, the Service Payments for the Elderly and Disabled (SPED) and Expanded SPED programs were selected for a performance audit. The purpose of this report is to provide our analysis, findings, and recommendations regarding our review of the SPED and Expanded SPED programs.

Background Information

Both the SPED and Expanded SPED programs are home and community-based services programs that are meant to delay or prevent institutionalization of individuals. The SPED program functions as an alternative to nursing home care while the Expanded SPED program functions as an alternative to Basic Care. Eligibility for both programs is determined at the county level. The Aging Services Division within DHS is responsible for enrolling Qualified Service Providers (QSPs) who, as independent contractors, provide services to the clients.

Results and Findings

We reviewed the current billing and payment process and performed tests on a sample of QSPs at selected counties. We also reviewed the case management process and performed tests on a sample of clients at selected counties. Finally, we reviewed the eligibility process for both clients and QSPs and performed tests on a sample of clients and QSPs. An independent consultant also performed reviews of client eligibility determinations and case management services provided. All recommendations are listed in Appendix B. Discussions relating to individual recommendations are included in Chapters 2 through 4 of this report.

Billing and Payment Process

Through tests performed at 12 selected counties and a review of additional information, we identified improvements that are necessary to increase the efficiency and effectiveness of payments to QSPs. Improvements should be made to ensure that QSPs are not providing more services than are authorized. Additional controls need to be implemented to monitor duplicate payments that are occurring with the computer system. Also, changes should be implemented to ensure that QSPs are not exceeding 200 hours of care in a month unless an emergency or unusual circumstance exists. Additional monitoring and management controls need to be implemented to ensure program funding is used appropriately and efficiently, and inconsistencies noted with the counties are changed. Due to a number of problems noted with the computer system used to process claims, changes need to be made to ensure that claims are processed correctly and efficiently. Finally, documentation supporting the billings of QSPs needs to be improved and monitored.

Case Management Services

Through tests performed at 12 selected counties and review of additional information, it appears that case management services are, for the most part, being effectively provided to clients of the SPED and Expanded SPED programs. However, we noted areas requiring improvements and

therefore, case management services are not provided as efficiently as they could be. Additional guidance and training related to case management should be provided to the counties. In addition, monitoring of case management billings should be conducted and changes should be made to the rate setting process for case management services.

Client and Provider Eligibility

Through tests performed at 12 selected counties and review of additional information, it appears that the client eligibility determination is, for the most part, being effectively accomplished by the counties. However, this determination assumes that the financial information declared by the clients is accurate. We did note that controls should be implemented related to the income and asset information provided by applicants and clients.

Through tests performed on a sample of QSPs and review of additional information, improvements are necessary to increase the effectiveness of the eligibility process used for enrolling applicants as QSPs. We noted changes should be made to the screening requirements and process used to enroll applicants as QSPs. In addition, a determination should be made as to the changes needed to obtain additional authority for denying applicants for enrollment as QSPs.

Chapter 1

Introduction

Purpose and Authority of the Audit

The Office of the State Auditor conducted a risk analysis on all of the programs within the Department of Human Services (DHS). The Risk Analysis report (#3015) dated May 25, 1999, identified a risk assessment rating for each program based on certain risk criteria. Based on the results of the risk analysis, the Office of the State Auditor made a determination to conduct a performance audit of the Service Payments for the Elderly and Disabled (SPED) and Expanded SPED programs.

A performance audit is an objective and systematic examination of evidence for the purpose of providing an independent assessment of the performance of a government organization, program, activity, or function in order to provide information to improve public accountability and facilitate decision-making by parties with responsibility to oversee or initiate corrective action. The purpose of this report is to provide our analysis, findings, and recommendations regarding our review of the SPED and Expanded SPED programs.

Background Information

The SPED program was established in 1983. SPED is a home and community-based services program that is meant to delay or prevent institutionalization of individuals. DHS enrolls Qualified Service Providers (QSPs) to provide in-home and community-based services for functionally impaired older individuals and persons with physical disabilities who need the assistance of another person to continue to live in a home or community setting. The SPED program functions as an alternative to nursing home care. Funding for the SPED program is 95% State general funds with a 5% county match.

The Expanded SPED program was implemented in September 1994. Expanded SPED is similar to SPED in that it is a home and community-based services program that uses Qualified Service Providers (QSPs) enrolled with DHS. Expanded SPED has the same eligibility requirements as Basic Care and serves as an alternative to Basic Care by providing services in the home or community to delay or prevent institutional care. Funding for the Expanded SPED program is 100% State general funds.

Client eligibility for both the SPED and Expanded SPED programs is determined at the county level. The county conducts an assessment of an individual and, if the individual qualifies for services, the county authorizes the type of services to be provided as well as the maximum amount of services which are to be provided. The Aging Services Division within DHS sets monthly maximum amounts for specific services and the total dollar amount of services a client can receive in a month. Beginning September 1, 2000, SPED and Expanded SPED funds could not exceed $1,200 a month per client unless specific authorization was provided by the division. The client may have to pay a portion of the costs of the services received. This cost is adjusted for family size and monthly income.

The SPED program operates as a self declaration program. Applicants for services and clients receiving services are required to provide income and asset information and there is no requirement of the counties to verify the information that is provided. Income information provided by the client is used to determine what percentage, if any, the client will be required to pay for services. Asset information provided by the client is used to determine eligibility. The Aging Services Division contends that the self declaration aspect of the programs is being used due to legislative intent from the 1989 Legislative Session. We attempted to identify legislative intent surrounding the self declarations of clients but were unable to do so. The Expanded SPED program is not a self declaration program as an applicant must be Medicaid eligible and the county is required to verify income and asset information of Medicaid applicants.

The SPED and Expanded SPED programs offer the following services to clients (a description of each service is identified in Appendix A):

- Adaptive assessment (Expanded SPED only)
- Adult day care
- Adult family foster care
- Case management
- Chore service
- Emergency response system (Lifeline)
- Environmental modification
- Family home care
- Homemaker
- Non-medical transportation
- Personal care service
- Respite care

QSPs are enrolled by the Aging Services Division as independent contractors. QSPs determine their own rates up to maximum amounts established by the Aging Services Division. A list of QSPs is provided to each county and the county is responsible for identifying this list of QSPs to each client. Clients of the SPED and Expanded SPED programs are allowed to select the provider of their choice. Clients can either choose a QSP from the list identified by the county or identify someone who would be willing to be enrolled as a QSP. Based on information obtained from the Aging Services Division, there were 1,785 QSPs enrolled as of February 2001. This total is comprised of 1,647 individuals and 138 agencies (which includes the 53 County Social Services Boards). The Aging Services Division identified 1,720 clients who received services from July 1, 2000 through December 31, 2000.

The Aging Services Division within DHS is responsible for the SPED and Expanded SPED programs. No SPED or Expanded SPED funds are used for salary or administrative costs of the division as these are budgeted under DHS's overall administrative budget for the Aging

Services Division. Relevant program expenditures are identified in the table below. The program expenditures are identified by service category in Appendix C.

Table 1
SPED and Expanded SPED Program Expenditures[1]

	FY 1999	FY 2000	FY 2001
SPED	$5,365,462	$5,674,149	$6,790,718
Expanded SPED	454,452	626,750	710,440
Totals	5,819,914	6,300,899	7,501,158
General Funds	5,551,594	6,016,990	2,899,213
Special Funds[2]	268,320	283,909	4,601,945

[1] Data obtained from the Statewide Accounting and Management Information System.

[2] Special Funds for FY 1999 and 2000 represent the 5% county match for the SPED program. For FY 2001, Special Funds include the 5% county match plus funds from the health care trust fund (Intergovernmental Transfer, IGT, program) which were used in FY 2001 to allow the funds to accrue interest for as long as possible.

Goals of the Audit

North Dakota Century Code Section 54-10-01 requires our office to conduct performance audits in accordance with generally accepted government auditing standards. The goals of our audit, listed below, include the necessary elements of a performance audit done in accordance with generally accepted government auditing standards.

Goal One Are payments to Qualified Service Providers made efficiently and effectively?

Goal Two Are case management services being efficiently and effectively provided to clients?

Goal Three Is the eligibility determination of Qualified Service Providers and clients receiving services effectively accomplished?

Scope Limitation

As part of this performance audit, we attempted to determine the effectiveness of the self declaration aspect of the SPED program. For the sample of clients reviewed, we attempted to determine if the income and asset information declared by clients was reasonable. To conduct this test, we attempted to gain access to income tax returns maintained by the Office of the State Tax Commissioner. However, the Tax Commissioner refused to cooperate and denied us access to tax returns. An Attorney General's Opinion was requested and the Attorney General determined that our office could not review income tax returns of SPED and Expanded SPED clients to verify the accuracy of the financial information provided by the clients. The Attorney General determined

that our office only has access to the tax returns during an audit of the Tax Department. A copy of this opinion can be seen in Appendix F. Due to the lack of access to income tax returns, a determination could not be made as to the effectiveness of self declaration as no reliable income and asset information could be identified for comparison purposes.

Scope and Methodology

This audit was conducted in accordance with generally accepted government auditing standards and accordingly includes appropriate performance auditing and evaluation methods. Audit fieldwork was conducted from April 17, 2001 through October 26, 2001. The audit period for which information was collected and reviewed was July 1, 1998 through December 31, 2000. In certain cases, subsequent information was reviewed. This was due, in part, to review and provide updated information related to payments for services and provider eligibility determinations. Specific methodologies are identified in the respective chapters of this report. The scope of our audit included a review of client case files at 12 county offices. The 12 counties selected for testing are listed below. Eddy and Wells County share the same case manager for the SPED and Expanded SPED programs, therefore the two counties were identified as one for our testing purposes. Some of the counties were selected due to their size, certain counties were judgmentally selected, and others were selected randomly.

- Benson County
- Burleigh County
- Cass County
- Eddy/Wells County
- Grand Forks County
- Morton County
- Nelson County
- Ramsey County
- Rolette County
- Stark County
- Stutsman County
- Ward County

Billing and Payment Process

Introduction

One of the goals of this performance audit was to answer the following question:

> "Are payments to Qualified Service Providers made efficiently and effectively."

Through tests and reviews performed on a sample of providers at 12 selected counties, improvements are necessary to increase the efficiency and effectiveness of payments to Qualified Service Providers (QSPs) of the SPED and Expanded SPED programs. We noted a number of areas where more program funds were being expended than was necessary. The Aging Services Division needs to establish additional monitoring and management controls over the SPED and Expanded SPED programs. Changes also need to be made to the computer system to ensure that claims are processed correctly and efficiently. Finally, improved documentation needs to be maintained by QSPs to support billings. These improvements are discussed in this chapter and improvements of less significance were communicated to management in a separate letter.

To identify the current billing and payment process for SPED and Expanded SPED claims, we:

- Reviewed the laws, rules, policies, and procedures surrounding case management services;
- Identified the billing cycle for SPED and Expanded SPED claims;
- Conducted a limited review of controls within the Medicaid Management Information System (MMIS);
- Selected a sample of 192 Qualified Service Providers (QSPs) at 12 selected counties;
- Reviewed a sample of billings for the 192 QSPs; and
- Interviewed selected county staff and the Department of Human Services, Aging Services Division staff.

Authorizing of and Payments for Services

When an aged or disabled individual is in need of services, the individual must complete a request for services form with the county social services office in the county in which they reside. A case manager at the county office conducts a comprehensive assessment of the applicant and a determination as to the applicant's eligibility is determined.

When an applicant meets eligibility criteria for the SPED or Expanded SPED program, the case manager and the client determine the client's needs, and the case manager completes the Individual Care Plan (ICP). The ICP lists the Qualified Service Provider (QSP) or QSPs selected by the client to perform the applicable service or services. The case manager identifies the monthly number of units per service that the listed QSP is authorized to provide. The QSP's unit rate is identified to arrive at the cost per month which is not to be exceeded by the QSP. The cost per month authorized by the counties cannot exceed the monthly maximum amounts established by the Aging Services Division.

When a QSP provides authorized services to a SPED or Expanded SPED client, the QSP submits a bill to the Department of Human Services for payment. Generally, this is done on a monthly basis. The QSP must provide certain information electronically or on the standard paper billing form to receive payment. Claims are processed on the Medicaid Management Information System (MMIS) and payments are made.

Making Improvements to the Processing of Claims

Through a review of a sample of billings for 192 Qualified Service Providers, there are changes necessary to improve the efficiency and effectiveness of the billing, processing, and payments of SPED and Expanded SPED claims. We noted that authorized amounts and monthly service maximum amounts are being exceeded by providers. We also noted that the computer system is not processing claims as effectively as it should and is allowing duplicate payments to occur. Finally, providers' documentation to support billings is insufficient.

Ensuring Authorized Amounts are not Exceeded

Case managers at the county level assess the needs of clients in the SPED and Expanded SPED programs. Based on the client's needs, the case managers establish a care plan that authorizes the maximum amount of services a client is to receive. This authorization is not to be exceeded by the Qualified Service Provider (QSP) selected by the client to perform the needed service. We performed a review to determine if authorized amounts were being exceeded.

We selected 12 counties for review and identified a sample of 192 QSPs at the selected counties. We then identified the clients receiving services from these QSPs and reviewed selected billing and payment information. Since a QSP may be providing services to more than one client, we reviewed between one and three clients for each QSP, dependent upon the number of clients identified with each QSP. Through this process we identified 245 clients. However, certain clients identified were receiving services from multiple providers. Due to this, the same client may have been reviewed with different providers.

We reviewed selected billing information and determined if QSPs had been paid within the amounts authorized by the counties. Of the 192 QSPs reviewed, we identified 33 (17%) who had billed and were paid funds that exceeded authorized amounts. We determined the amount of these overpayments to our sampled QSPs to be approximately $8,470. In addition, certain providers were identified as exceeding a service monthly maximum amount that is established by the Aging Services Division.

After the county authorizes services, there are very few controls in place to ensure that QSPs are only paid for what has been authorized. The counties do not monitor QSP billings and, in fact, only appear to review billings when complaints or problems are identified with a provider. The Aging Services Division annually conducts reviews of a sample of QSPs

and monitors QSP billings when complaints or problems are identified with a provider. The Medicaid Management Information System (MMIS) does not monitor claims to ensure that authorized amounts are not exceeded. We noted only a single control and edit check in MMIS specific to the SPED and Expanded SPED programs. The control ensures that the client monthly maximum amount is not exceeded (maximum per month per client as of September 1, 2000 was $1,200). MMIS does not have controls or edit checks programmed to ensure that specific service monthly maximum amounts are not exceeded or that authorized amounts are not exceeded. Due to the lack of controls and monitoring in this area, funds have been used in an inefficient manner.

Recommendation 2-1

We recommend the Aging Services Division implement controls to ensure that authorized amounts for services to clients are not exceeded by the Qualified Service Providers.

Management's Response

The Department agrees with the recommendation. The Aging Services Division will update its HCBS review protocol to increase controls to assure that authorized amounts for services to clients is not exceeded by Qualified Service Providers.

Implementing Additional Controls to Prevent Duplicate Payments

Through a review of billing and payment information for one Qualified Service Provider (QSP) selected for testing, it was determined that the Medicaid Management Information System (MMIS) allowed duplicate payments to be made to the QSP. A duplicate payment is a payment made to the QSP for the same services provided to the same client on the same service date. As a result, we expanded testing to perform a limited review for duplicate payments.

The Department of Human Services (DHS) explained there are controls surrounding duplicate payments in MMIS but a timing issue allowed the duplicate payments to occur. If duplicate claims for payment are entered in the system in the same week, but not paid, the duplication control will detect it. Once a claim has been paid it goes to a "paid" file. There is also a duplication control using this file. However, it takes approximately a week for the paid claim to hit the "paid" file. If a duplicate claim comes in after the original claim has been paid but before it hits the "paid" file, the duplication control will not detect it and a duplicate payment will be made. Representatives of DHS stated they were aware of the system's deficiency in this area and relied on QSPs to notify them when duplicate payments were made.

Using data obtained from MMIS for SPED and Expanded SPED claims, we identified 483 instances where duplicate payments appeared to have occurred. A sample of 100 was reviewed further to determine the dollar amount, the time lapse between payment dates, and if any of the payments had been reversed, reimbursed, or adjusted. All 100 instances reviewed were duplicate payments. Our review identified 34 duplicate payments had been reversed, reimbursed, or adjusted. The remaining 66 duplicate payments had not been reversed, reimbursed or

adjusted. These 66 resulted in $1,415 of excess payments. Without taking into account sampling error, this would project to approximately $6,800 that has not been reversed, reimbursed, or adjusted. The review also identified several instances where the cause of the duplicate payment was not because of the time lapse issue identified by DHS. Representatives of DHS were unable to explain why the edit checks in MMIS did not detect these duplicate payments.

MMIS is also the system used to process Medicaid claims. Based on discussions with representatives of DHS, it appears the same duplicate payment problems identified with SPED and Expanded SPED claims could occur with Medicaid claims. DHS was not able to identify any additional controls or edit checks that would prevent these duplicate payments from happening with Medicaid claims. In fiscal year 2000, over $250 million in Medicaid claims was processed through the system. We have identified the duplication payment problem to the financial auditors within our office and they will be reviewing the duplicate payments of Medicaid claims.

Recommendation 2-2

We recommend the Department of Human Services implement additional controls to monitor duplicate payments on MMIS.

Management's Response

The Department agrees with the recommendation. The MMIS system used by the Department to pay claims is approximately 25 years old and is built on a batch method that requires two weeks for claims to be completely processed. ITD has estimated that it will take a minimum of over 400 hours and possibly many more hours to correct this problem. Due to the time constraints of HIPAA, we will not be able to make the changes until sometime in 2003.

The Department is in the process of establishing the following mitigating controls:

1. Hiring a payment accuracy measurement staff person to sample claims to determine that Medicaid is properly paying the claim. This will include a review of claims starting with provider documentation of the service all the way through claims payment. The funding for this temporary position is funded 100% with Federal Funds.
2. Working with the dataprobe software and the Medstat group to develop a query which will identify any duplicate claims and review those on an ongoing basis.

Ensuring Providers do not Exceed 200 Hours of Care a Month

North Dakota Administrative Code Section 75-03-23-09 subsection 10 states that Qualified Service Providers (QSPs) are limited to a maximum of 200 hours of care per month unless an emergency or unusual circumstance exists. Through tests performed in the sample of 12 counties, one QSP was identified as providing more than 200 hours of service in a month. We then expanded testing to providers in all 53 counties using data obtained from MMIS.

Based on the data obtained from MMIS for our audit period (July 1, 1998 through December 31, 2000), we identified 11 QSPs who provided over 200 hours of service in a month without approval from the Aging Services Division. These 11 QSPs provided more than the maximum number of hours in a month 82 times. We noted one QSP who billed and was paid for over 200 hours a month 26 times. The hours of service provided by this QSP in these 26 months ranged from 207 hours to 261 hours in a month. We also noted a QSP who billed and was paid for providing 422 hours of service. This equates to this QSP providing, on average, over 13 hours of service a day.

Recommendation 2-3

We recommend the Aging Services Division implement controls to ensure that individual Qualified Service Providers do not provide more than 200 hours of service in a month unless an emergency or unusual circumstance exists.

Management's Response

The Department agrees with the recommendation. The Aging Services Division will update its HCBS review protocol to increase a focus in monitoring to ensure that individual QSPs do not provide more than 200 hours of service unless an emergency or unusual circumstance exists as per N.D.A.C. Section 75-03-23-09. The Aging Services Division will work with the Medical Services Division to implement controls in monitoring turnaround documents that exceed 200 hours of service per month.

Implementing Additional Monitoring and Management Controls

In addition to the areas requiring improvement mentioned above, we also identified other areas that have negative impacts on the SPED and Expanded SPED program's efficiency and effectiveness. These areas include:

- We identified clients who were on both the SPED program and the Medicaid Waiver program at the same time. The reasons for these clients being on both of these programs at the same time is due to the fact that the Medicaid Waiver program does not pay for Family Home Care services. Thus, if an individual is on the Medicaid Waiver program and is receiving Family Home Care, SPED funding is used to pay for the Family Home Care services and Medicaid Waiver program funding is to be used to pay for all other services received by the client (such as respite care services, chore services, and case management services). The 12 selected counties identified 28 clients that were on both the SPED and Medicaid Waiver programs at the same time. Through a review of billing information on MMIS, we identified six (21%) who had SPED funding pay for services other than Family Home Care. This resulted in $12,700 of SPED funds being inefficiently and inappropriately used.
- Through tests performed at the counties, we noted that a QSP billed and was paid for providing services to a client who was in the hospital at that time. Thus, the services being billed could not have been provided since the client was in a hospital.

- The Aging Services Division established a QSP complaint log starting in the spring of 2000. Through review of this document, a QSP was identified as being in jail for domestic violence and public intoxication for part of a month. The QSP billed and was paid for providing services for the entire month. The complaint log identified other instances in which a provider billed and was paid for services that were not provided.
- Through discussions with case managers at 12 selected counties and a review of authorization information, five counties authorize the number of units for services (to be provided on a unit rate basis) on a 30 day basis and thus, in a 31 day month a provider may exceed the authorization units. The other seven counties stated that the number of units authorized for services on a unit rate basis is not to be exceeded regardless of the number of days in a month. This may result in confusion with Qualified Service Providers (QSPs) who provide services in one or more counties.
- When the client's level of care requires services to be delivered on a daily rate rather than a unit rate, the case manager at the county completes a monthly rate worksheet to identify a daily rate that will be charged by the provider. Daily rates can be used to provide Family Home Care, Adult Family Foster Care, and Personal Care. Through a review of 104 monthly rate worksheets at the counties visited, we identified 10 (10%) that were not properly completed. Of the ten, six resulted in an incorrect daily rate being used.

The items listed above, as well as the other areas previously identified in the report, require improvements to increase the efficiency, consistency, and effectiveness of the SPED and Expanded SPED programs.

Recommendation 2-4

We recommend the Aging Services Division implement additional monitoring procedures and management controls for the SPED and Expanded SPED programs. At a minimum, the division should:

a) Ensure SPED funds are not used for eligible Medicaid Waiver expenses;
b) Ensure program funds are spent for services actually provided;
c) Increase consistency in establishing the authorized units of service to be provided to clients; and
d) Increase compliance with completing the monthly rate worksheet.

Management's Response

The Department agrees with the recommendation. The Aging Services Division does have in existing policy references that require the CSSB to prioritize the use of the Medicaid Waiver funding source as a first priority. The Aging Services Division will review policy and procedures that apply to the recommendation and increase the strength of emphasis that eligible Medicaid Waiver clients must use the Medicaid Waiver funding source as a first priority for payment of In-Home and Community Based support services. The Aging Services Division will include this topic at its next HCBS Case Manager training session. The Aging Services Division will update its HCBS review protocol to increase a focus in monitoring to

ensure program funds are spent for services actually provided. The Aging Services Division will provide training on the topic of establishing consistency of authorized units of service to be provided to clients. The Aging Services Division will implement a monitoring procedure to check every Monthly Rate Worksheet received by the Division is accurate.

Making Changes to the Computer System

Through a limited review of the controls and edit checks within the Medicaid Management Information System (MMIS) and tests performed at 12 selected counties, we identified a number of edit checks and controls that were not in place or were not working properly. Examples include:

- A provider can bill and be paid for services that exceed 24 hours in one day;
- A procedure code of another program can be used to bill and be paid with SPED or Expanded SPED funds;
- Maximum monthly amounts for individual services, as established by the Aging Services Division, can be exceeded;
- A provider can bill and be paid for services that are not authorized;
- A procedure code with a flat unit rate can be billed and paid with a unit rate other than a flat rate; and
- A claim will be processed and paid even if the claim identifies a later start date for services than the date the services ended.

Due to the problems noted, it appears MMIS is not correctly processing and identifying errors on claims and as a result, SPED and Expanded SPED funds are used inefficiently. Based on discussions with representatives of the Department of Human Services, it appears there is only one specific control or edit check that has been added to MMIS. This edit check is programmed to suspend claims when the total amount of services to a client exceeds the SPED or Expanded SPED monthly maximum amounts.

Recommendation 2-5

We recommend the Department of Human Services review controls in MMIS and take the appropriate actions to ensure that SPED and Expanded SPED claims are processed correctly and efficiently.

Management's Response

The Department agrees with the recommendation that the controls in the MMIS system be reviewed. These will need to be reviewed, and coordinated with other Aging Service's mitigating controls. Each change regarding the controls will need to be individually reviewed to determine if the benefits of implementing a specific edit check in the MMIS program outweighs the cost of implementing the change or if other mitigating controls can be developed to minimize the incorrect payment risk.

Additionally, the Department does try to make the provider aware of the importance of the payment requests they are submitting by requiring the Qualified Service Provider sign the Medicaid Program Provider Agreement at the time of enrollment. The agreement contains language assuring the provider attests to the accuracy and truthfulness when they

seek payment for services rendered. Additionally each billing document requires a signature from the provider attesting to the accuracy of the claim and states that if the information is falsified the provider may be prosecuted under applicable federal or state law.

Improving Provider's Logs

The Aging Services Division provides information to Qualified Service Providers (QSPs) informing them of the requirement to maintain a provider log. The provider log is the written record for each client that documents the delivery of care for which a QSP seeks payment. The record must identify each date/day of service, beginning and ending time in the client's home, and the tasks performed during that time.

During our visits to the 12 selected counties, we requested the case managers contact a sample of QSPs and request their provider logs. Of the 50 QSPs contacted, 17 did not provide a copy. According to the case managers, a number of QSPs stated they no longer had the provider logs because they were no longer providing care for the clients. The Aging Services Division requires the documentation be maintained for a period of 42 months from the close of a federal fiscal year in which services were delivered or until an audit is completed and closed, which ever occurs first. Of the 33 provider logs submitted, nine (27%) did not have the required documentation.

Recommendation 2-6

We recommend the Aging Services Division:

a) Better communicate the requirements of provider log documentation and records retention requirements to the Qualified Service Providers; and
b) Monitor the Qualified Service Provider logs to ensure provider log requirements are complied with.

Management's Response

The Department agrees with the recommendation. The Aging Services Division will review controls in place and strengthen components of communication and monitor Qualified Service Providers requirements to complete provider log documentation and records retention.

Case Management Services

Introduction

One of the goals of this performance audit was to answer the following question:

> "Are case management services being efficiently and effectively provided to clients?"

Through tests and reviews performed by both our office and the consultant on a sample of clients at 12 selected counties, it appears that case management services are, for the most part, being effectively provided to clients of the SPED and Expanded SPED programs. However, we noted a number of areas requiring improvements and as a result, case management services are not as efficiently provided as they could be. Therefore, additional funds may be spent on case management services instead of being available for the direct delivery of services to clients. There is a need for improved guidance and additional training in the case management area. Also, monitoring of case management billings should be established and improvements should be made in the rate setting process. These improvements are discussed in this chapter of the report.

To identify the current case management processes and procedures, we:

- Reviewed the laws, rules, policies and procedures surrounding case management services;
- Reviewed the rate setting process for case management services;
- Selected a sample of 12 counties;
- Reviewed a sample of 246 SPED and Expanded SPED cases at the selected counties; and
- Interviewed selected county staff and the Department of Human Services, Aging Services Division staff.

Defining Case Management Services

Case management is the process in which case managers at the county level are providing specialized assistance to aged and disabled individuals who desire and need help in selecting and/or obtaining resources and services. Case management also coordinates the delivery of the services to assist functionally impaired persons to remain in the community. Case management is to provide the link between community resources, Qualified Service Providers, and the clients accessing needed services.

Case management services are provided to SPED and Expanded SPED clients by the case managers in their respective county. The Aging Services Division requires the case managers to make a minimum of four contacts with a client in a 12 month period. These four contacts require two home visits to be conducted at six month intervals and the other two contacts can be made by telephone, office visit, or a home visit.

Case management services are billed by the counties using one of two procedure codes. Procedure code 00017 is to be used for the initial and annual assessments of clients. Procedure code 00015 is to be used to bill all other case management activities. Both of these procedure codes utilize a standard rate and the county can bill for case management activities regardless of the length of time spent on the particular activity. Thus, a 15 minute contact is billed at the same amount that a 3 hour contact is (assuming the same procedure code is used).

Through surveys and discussions with the counties, it appears that certain counties believe that case management services are not fully reimbursed by the Department of Human Services (DHS). Based on our review, we believe that case management services provided to SPED and Expanded SPED clients are being reimbursed by DHS per the current rate setting process. The only instances we noted in which case management services were not reimbursed by DHS were when the county failed to bill for services or the county conducted an assessment of an applicant and the applicant was not eligible for SPED or Expanded SPED services.

Making Improvements to Case Management Services

Through tests performed by both our office and the consultant on a sample of cases, it appears that case management services are, for the most part, being effectively provided to clients of the SPED and Expanded SPED programs. However, there are changes that are necessary to improve the efficiency of case management services. We noted inconsistencies in case management billing practices, case management billings that were not supported by documentation, and activities being billed for case management that were not reasonable.

Providing Additional Guidance and Training

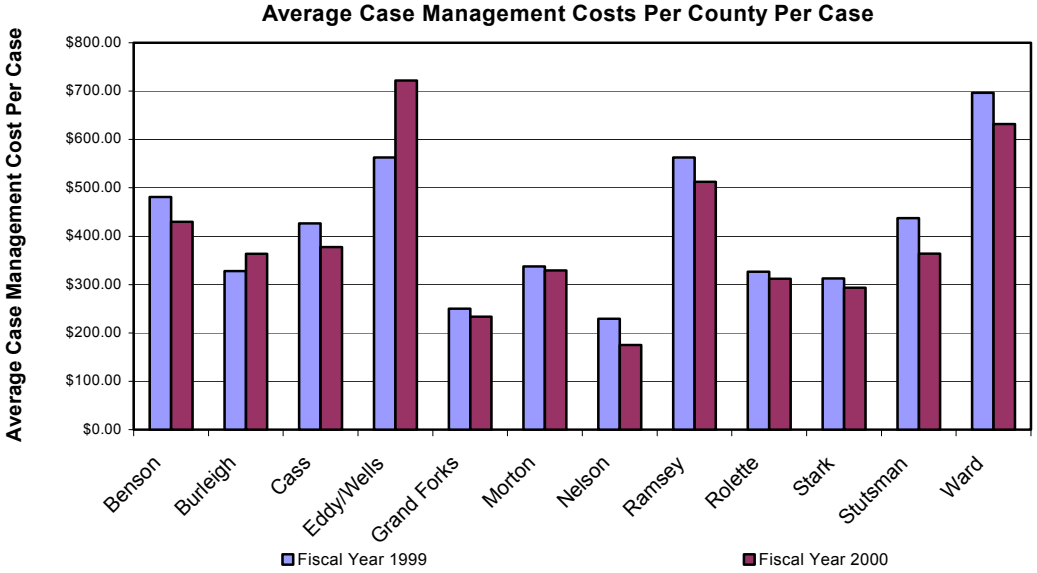
At the 12 selected counties, we reviewed a sample of 245 clients. Using case management requirements established by the Aging Services Division, tests were performed.

Case managers at the county level are required to make a minimum of four contacts with a client in a 12 month time period. In addition, case managers are required to have contact with a new client (one that has not previously received Home and Community Based Services) within the first 30 days of implementation of services. For the most part, case managers are making the required four contacts in a 12-month period, however there is a need for improvement in contacting new clients. Of the new clients identified in our review (117), we identified that 18 (15% error rate) did not have the required 30-day contact. This 30-day contact is established to ensure that services are appropriately provided to new clients who are at a higher risk of not understanding the program or having knowledge of the service delivery processes than those clients who have been receiving services. As a result, case management services to new clients are not as effective as they could be.

Chapter 3
Case Management Services

Through a comparison of case management billings to the documentation that is required, we identified a number of case management billings that were not supported by documentation or were not reasonable. Of the 245 clients reviewed, 240 clients had case management services that were billed to the SPED or Expanded SPED program (there were five clients who were on the Medicaid Waiver program and SPED program at the same time and when this occurs, the Medicaid Waiver program is to pay for case management services). Our review identified approximately 37% of the clients had case management services billed to one of the two procedure codes used for case management that were not supported by documentation or which we believe should not have been billed. Examples include:

- Lack of Documentation – We noted case management billings that were not supported by documentation in the client's file. Requests for reimbursement by the counties are required to be supported by documentation in the client's case file that case management service activities were completed.
- Inappropriate Billings – We noted case management billings that were for certain activities (such as administrative tasks) that do not appear to comply with the definition of case management services.
- Inordinate Number of Billings – We noted in certain instances that case management activities appeared to take place continuously, month after month. These instances appeared to be occurring in one county in particular (Ward County) and the case management billing practices in this county were different than what was identified in the other counties reviewed. Due to these differences, the average case management costs for the clients reviewed was determined. The graph below identifies the average case management costs for clients who had received services for a minimum of nine months in the applicable fiscal year.



Eddy/Wells and Ramsey County contain only one case in Fiscal Year 1999

In addition to the above instances, we also noted inconsistencies not only between counties but also within the same county. We noted similar case management activities being billed by certain counties that were not billed by other counties. In addition, we noted that within the same county, similar case management activities were billed sometimes but not other times. Through the work performed and information provided by the counties, we noted that certain counties were unaware of what activities could and could not be billed for case management services. We also noted there is a need for improvement in the guidance provided to counties.

The problems noted above with case management billings result in resources not being used in the most efficient manner. As a result, this has an impact on the amount of funds available for direct services to clients as funding for the SPED and Expanded SPED programs is budgeted as a total amount and does not distinguish between funds to be used for case management or for direct service delivery. Thus, when case management is inappropriately billed and paid, funds that would have been available for direct service delivery to clients, improperly goes to the county. In addition, the 2001 Legislature passed Targeted Case Management which will mean that federal funds will be used for case management costs for those clients that are eligible for Medicaid. Therefore, it is critical that case management costs are appropriately billed since federal funds used for ineligible costs may result in repayment of costs, plus interest and penalties, to the federal government.

Recommendation 3-1

We recommend the Aging Services Division provide additional guidance for case management by developing and implementing policies and procedures that, at a minimum:

a) Define case management and identify what can and can not be billed;
b) Define administrative tasks; and
c) Identify case management documentation requirements.

Management's Response

The Department agrees with the recommendation. The Aging Services Division will identify and chart the tasks/activities that are allowed within the scope of HCBS Case Management as well as chart the tasks/activities that are defined as administrative tasks. The Aging Services Division will work with the Department's Fiscal Administration Division to establish the commonly accepted standards that define administrative tasks.

Recommendation 3-2

We recommend the Aging Services Division provide additional training to the counties in the case management area. This may require training to be tailored to specific counties and/or individual case manager needs.

Management's Response

The Department agrees with the recommendation. The Aging Services Division sponsors one annual HCBS Case Management Training session every Spring and Fall. The Aging Services Division will

schedule training for HCBS Case Managers that focuses on the service of HCBS Case Management. At least annually the Aging Services Division schedules "HCBS 101" for all newly hired HCBS Case Managers. We will continue this practice. The Aging Services Division will review the roster of all HCBS Case Managers in the state and schedule training specific to needs of individual Case Managers.

Monitoring Case Management

Case management services are being provided to SPED and Expanded SPED clients by case managers at the county level. The Aging Services Division visits each county annually and conducts a review of case management services and expenditures for a sample of clients. Through tests performed on a sample of clients at 12 selected counties, we identified inconsistencies in case management billing practices, case management billings that were not supported by documentation, and activities being billed for case management that were not reasonable. To assist in ensuring funds are used appropriately and that the maximum amount of funds are available for the direct delivery of services to clients, the Aging Services Division needs to increase monitoring of case management billings.

Recommendation 3-3

We recommend the Aging Services Division monitor case management billings by:

a) Periodically performing analytical reviews of case management billing data; and
b) Comparing case management billings to case file documentation.

Management's Response

The Department agrees with the recommendation. The Aging Services Division will develop protocol to complete at least quarterly analytical reviews of case management billing data. The Aging Services Division will coordinate this protocol with the Medical Services Division with respect to its' management of MMIS. The Aging Services Division will update its HCBS review protocol to increase a focus on comparison of case management billings to case file documentation.

Changing the Rate Setting Process

When a county submits a billing for case management services, the county must bill one of two procedure codes. One procedure code, 00017, is to be used for the initial and annual assessments of clients. The other procedure code, 00015, is to be used to bill all other case management activities. Both of these procedure codes utilize a standard rate and the county can bill for case management activities regardless of the length of time spent on the particular activity. Thus, a 15 minute contact is billed at the same amount that a 3 hour contact is (assuming the same procedure code is used). The Aging Services Division believes that these types of differences will "even out in the long run" (i.e. shorter contacts that are billed are evened out by longer contacts that are billed). However, we observed no evidence to support this assertion.

During the audit time period, the rates that were established for each procedure code are identified in the table on the following page.

Table 2 Case Management Rates		
Effective Date	Procedure Code 00017	Procedure Code 00015
September 1, 1996	$125	$62.50
January 1, 2000	$130	$65
September 1, 2000	$135	$70

It is important to note that these rates are not based on costs incurred by the counties. We attempted to determine an hourly case management billing rate using billing information identified on the Medicaid Management Information System (MMIS) and information documented on case narratives at the 12 counties we visited. However, only two counties documented the amount of time spent for each monitoring activity on the case narrative. Therefore, this determination was made for only two counties. For a limited sample of clients at the two counties, an hourly billing rate was determined. For the selected clients, we identified the billing rate for the two counties combined to be $80.60 an hour. Based on a review of the hourly wages of social workers within the state's personnel system, the hourly billing rate computed at the two counties appears excessive.

Through discussions with the Aging Services Division, there have been no cost studies or any other reviews performed to determine the reasonableness of the standard rates used for case management. According to management of the Department of Human Services (DHS), this is a sensitive issue as reliable cost data for case management services is difficult to obtain from the counties as no standard statewide system exists for allocating time and costs to the various services counties provide. The department also stated that there are differences in opinions between the counties and DHS regarding the reasonableness of the current rates used.

Recommendation 3-4

We recommend the Aging Services Division make changes to the rate setting process for case management. At a minimum, the division should:

a) Consider setting the case management rates based on costs or a percentage of program funding;
b) Have adequate documentation for justifying the rate setting process for case management; and
c) Ensure periodic review of the case management rates.

Management's Response

The Department agrees with the recommendation. The Aging Services Division will work with the Department's Fiscal Administration Division and establish a commonly accepted standard for case management service rate setting including costs and supporting documentation. Case Management rates will be scheduled for periodic review at least one time each biennium.

Chapter 4

Eligibility of Clients and Providers

Introduction

One of the goals of this performance audit was to answer the following question:

> "Is the eligibility determination of Qualified Service Providers (QSPs) and clients receiving services effectively accomplished?"

Through tests and reviews performed by both our office and the consultant on a sample of clients from 12 selected counties, it appears that the client eligibility determination is, for the most part, being effectively accomplished by the counties. However, this determination assumes that the financial information declared by the clients is accurate. The Tax Commissioner and the Attorney General would not allow us to review tax returns to determine the validity of financial information declared by clients. If this financial information is not accurate, it dramatically affects the effectiveness of the client eligibility determination. We did note that the Aging Services Division needs to establish controls related to the income and asset information provided by applicants and clients of the SPED and Expanded SPED programs.

Through tests and reviews performed on a sample of Qualified Service Providers (QSPs), improvements are necessary to increase the effectiveness of the eligibility process used for enrolling applicants as QSPs. The Aging Services Division needs to make improvements to the screening requirements and processes used to enroll applicants as QSPs. The division should also determine the changes necessary to obtain additional authority to deny certain applicants for enrollment as QSPs. These improvements are discussed in this chapter and improvements of less significance were communicated to management in a separate letter.

To review the eligibility criteria and processes for clients and providers of the SPED and Expanded SPED programs, we:

- Reviewed laws, rules, and policies surrounding client and provider eligibility;
- Identified the process used in approving applicants to receive services;
- Identified the process used in enrolling Qualified Service Providers;
- Reviewed the client eligibility determinations made for a sample of 246 cases at 12 selected counties;
- Reviewed the provider eligibility determinations made for a sample of 80 providers;
- Reviewed a sample of other states information; and
- Interviewed selected county staff and the Department of Human Services, Aging Services Division staff.

Identifying Client Eligibility

For an individual to receive services under the SPED or Expanded SPED program, the individual must first visit their County Social Services Office and apply for services. A case manager in the county conducts an assessment of the individual and determines the necessary services to be provided to the individual. The county also determines the program under which the services will be provided. The county is to use the Medicaid Waiver program as a first option, however if the individual does not qualify for the program, then the SPED or Expanded SPED program is to be used based on the eligibility of the individual. Specific eligibility for the Medicaid Waiver, SPED, and Expanded SPED programs can be seen in Appendix D.

Improving the Self Declaration Process

The SPED program is operated as a self declaration program. This means that the income and asset information provided by an applicant or client is not required to be verified by the county. Representatives of the Aging Services Division stated that the self declaration aspect of the program was established in 1989 based on legislative intent. We attempted to identify legislative intent but were unable to find evidence of the intent of self declaration.

The income information provided by clients is used to determine a client's fee for service. The fee for service is a percentage amount that represents the amount of services the client is responsible to pay. The asset information provided by applicants and clients is used to determine eligibility.

As part of this performance audit, we attempted to determine the effectiveness of the self declaration process and the impact that it has on the program. For a sample of clients, we requested access to income tax returns to compare information on the tax returns to the information declared by the clients for the SPED program. However, the State Tax Commissioner refused to cooperate and did not allow us access to the tax returns. An Attorney General's Opinion was requested and the Attorney General determined that our office could not review income tax returns of SPED clients to verify the accuracy of the financial information provided by the clients. If access had been provided to the tax returns, we could have made a determination as to the effectiveness of the self declaration of income and assets and would have determined whether clients were truly eligible and were paying the appropriate amount for the services being provided.

While the counties and the Aging Services Division save time by not verifying the income and asset information declared by clients, there is a risk that the information provided may not be correct. As a result, ineligible individuals may receive services. Another result could be individuals are paying less than they should for services received. In either case, the final result is that eligible individuals may not receive services, given that resources were spent inappropriately. The Medicaid program does require verification of income and assets to be eligible for

the program. While self declaration may be the least intrusive to the clients, the Aging Services Division should have controls in place to ensure that self declaration is not having a negative impact on the SPED program.

Recommendation 4-1

We recommend the Aging Services Division implement procedures and establish controls related to clients' self declarations of income and assets.

Management's Response

The Department agrees with the recommendation. The Aging Services Division will study this recommendation to determine what additional controls may be needed related to client's self declaration of income and assets.

Making Changes to the Enrollment Process for QSPs

The Aging Services Division is responsible for enrolling individuals and agencies as Qualified Service Providers (QSPs). The QSPs are considered independent contractors. Through a review of the process used to enroll QSPs and a review of a sample of 80 QSP eligibility determinations, we noted improvements that are necessary to the screening requirements and processes used for enrollment. We also identified a need for additional authority to deny applicants for enrollment as QSPs.

Improving Screening Requirements

The Aging Services Division uses standard application forms in the enrollment process for QSPs. The forms require an applicant to provide certain information dependent upon the services they are requesting to provide. The forms require the signature of an appropriate individual (must be a third party) documenting the applicant's competency in the service areas in which the applicant will be providing services.

In a report issued by the U.S. Department of Justice entitled *Guidelines for the Screening of Persons Working with Children, the Elderly, and Individuals with Disabilities in Need of Support*, dated April 1998, the department encourages states to have basic screening practices, consider adoption of statutes authorizing criminal record checks, and have abuse prevention education and training. The report identifies basic screening practices as including appropriately developed applications, personal interviews, and reference checks. While Adult Family Foster Care requires both references and background checks, there appears to be no personal interviews conducted with QSPs. There are no requirements for reference checks, background checks, or personal interviews for any QSPs who provide services outside of Adult Family Foster Care, other than having an appropriate individual sign off on the competency forms. Based on information provided by a sample of other states, we identified eight out of ten states required background checks for certain providers and five of these states required background checks for providers who would be entering the client's home.

Recommendation 4-2

We recommend the Aging Services Division make improvements to the screening requirements and processes used to enroll applicants as Qualified Service Providers.

Management's Response

The Department agrees with the recommendation. The Aging Services Division has worked closely with the Internal Revenue Service and the Social Security Administration to assure the DHS is in an independent contract position with QSPs. Meeting the "tests" of the IRS and SSA may limit the DHS's ability to change screening requirements and processes for enrollment of QSPs. The Aging Services Division will work with the Department's Legal Services Unit to determine if screening requirements and processes for enrollment of QSPs can be changed.

Obtaining Additional Authority

Based on discussions with representatives of the Aging Services Division regarding the denial of applicants to be enrolled as QSPs, the division believes there must be a direct connection between an applicant's criminal activity and the care proposed to be provided in order for a denial to take place. The division noted that this interpretation was developed based on internal legal counsel's advice from approximately 10 years ago.

Since the Aging Services Division has the authority to enroll applicants as QSPs, the division should also have adequate authority to deny applicants for enrollment when the division determines it is necessary. We noted an applicant was enrolled as a QSP even though they were convicted of gross sexual imposition. We also noted an applicant was enrolled as a QSP even though they were convicted of Medicaid fraud in another state.

Recommendation 4-3

We recommend the Aging Services Division, in conjunction with appropriate legal counsel, review laws, rules, and policies related to denying applicants applying for Qualified Service Provider status and determine appropriate changes to provide additional authority to deny such applicants. The division should:

a) Take appropriate action to make necessary changes to laws, rules, and policies; or
b) Document the decision as to why such changes are not necessary.

Management's Response

The Department agrees with the recommendation. The Aging Services Division will work with the Department's Legal Services Unit to explore options where laws, rules, and policy changes can be made to add authority to deny QSPs from enrolling when deemed appropriate.

Additional Information

Noteworthy Accomplishments

Government Auditing Standards states that "Auditors should report noteworthy accomplishments, particularly when management improvements in one area may be applicable elsewhere."

As part of this performance audit, we surveyed clients, Qualified Service Providers (QSPs), case managers, and county directors. The surveys sent to case managers and county directors contained questions regarding the assistance and guidance provided by the Aging Services Division as well as the responsiveness of the division. The survey responses indicated an exceptionally high level of satisfaction with the division. The staff of the Aging Services Division should be commended on the high satisfaction level identified by the survey respondents.

Issues Requiring Further Study

Government Auditing Standards requires disclosure of significant issues identified during an audit that were not reviewed in depth. These are issues which are not directly related to the audit objectives or that the auditors did not have the time or resources to expand the audit to pursue. We identified one issue related to duplicate payments being made by the Medicaid Management Information System (MMIS).

SPED and Expanded SPED claims are processed on MMIS. However, the majority of claims processed on the system are Medicaid claims. Our testing identified duplicate payments being made for SPED and Expanded SPED claims. Based on discussions with representatives of DHS, it appears the same duplicate payment problems identified with SPED and Expanded SPED claims could occur with Medicaid claims. DHS was not able to identify any additional controls or edit checks that would prevent these duplicate payments from occurring with Medicaid claims. In fiscal year 2000, over $250 million in Medicaid claims were processed through the system. If the duplicate payments are also occurring in the processing of Medicaid claims, it could result in a significant amount of funds being inappropriately spent. Since a substantial portion of the Medicaid funding uses federal funds, these inappropriately spent dollars could result in a liability to the federal government.

A review could be performed to identify duplicate payments made with Medicaid claims. A review would then need to be performed to determine if the duplicate payments had been corrected and adjusted. We have identified the duplication payment problem to the financial auditors within our office and they will be reviewing duplicate payments involving Medicaid claims.

Appendices

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List of Recommendations B1

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Client Eligibility Requirements and Process D1

Comparison of Nursing Home Costs to SPED Costs E1

Attorney General's Opinion Regarding Access to Tax Returns F1

Glossary

Activity of Daily Living (ADL)

ADLs are those measurable activities that may be used to evaluate independence. They are used in determining SPED and Expanded SPED eligibility. ADLs include the following:

- Bathing
- Dressing and undressing
- Eating
- Toileting
- Continence
- Transferring in or out of bed or chair
- Ability to get around inside the person's home

Adult Day Care

Adult day care is a service for those over the age of 18 that encompasses activities needed to ensure the optimal functioning of the individual. The service may be offered in the provider's private residence or in an adult day care center. It must be provided three or more hours per day, on a regularly scheduled basis, one or more days per week. This service uses a half-day unit for billing and is covered under both the SPED and Expanded SPED programs.

Adult Family Foster Care

Adult family foster care is a service that provides for a safe, supervised family living environment in an occupied private residence with 24-hour care or supervision. This service uses a daily rate for billing and is covered under both the SPED and Expanded SPED programs.

Basic Care

Basic Care is a residence that provides room and board to five or more individuals who, because of impaired capacity for independent living, require health, social, or personal care services, but do not require regular twenty-four hour medical or nursing services.

Case Management

Case management is a service provided by case managers at the county level. Services include assessment, care planning, provider selection, monitoring of services, and making referrals. This service is billed using a standard rate that is used when a case manager performs at least one function of case management. This service is covered under both the SPED and Expanded SPED programs.

Chore

Chore is a service that allows one-time, intermittent, or occasional home tasks including housecleaning, minor home maintenance, minor home repair, select installations, and walk maintenance. This service uses a unit rate for billing (unit equals 15 minutes) and is covered under both the SPED and Expanded SPED programs.

Emergency Response System

Emergency response system is a service that includes an electronic device that enables individuals at high risk of institutionalization to secure help in an emergency. This system is connected to the person's phone and programmed to signal a response once a 'Help' button is activated. This service uses a monthly rate for billing and is covered under both the SPED and Expanded SPED programs. The cost of the installation is also provided for in both of these programs.

Environmental Modification

Environmental modification is a service that allows limited structural modification to the home that enables the recipient to function with greater personal independence and safety. This service uses a per modification rate for billing and is covered under both the SPED and Expanded SPED programs.

Expanded Service Payments for the Elderly and Disabled (Expanded SPED)

Expanded SPED provides payments for in-home and community-based services to persons who would otherwise receive care in a licensed Basic Care facility. The program has the same eligibility requirements as Basic Care and serves as an alternative to Basic Care. Services are provided by Qualified Service Providers who are enrolled by the Department of Human Services.

Family Home Care

Family home care is a service that provides room, board, supervisory care and daily personal care to eligible elderly or disabled individuals. The provider and the client must reside together. The provider must be a family member of the client. If the provider is the client's spouse, family home care must be used. According to the Aging Services Division, North Dakota is the only state that provides this service to aged and disabled individuals. This service uses a daily rate for billing and is covered under both the SPED and Expanded SPED programs.

Fee for Services

Fee for services is the percentage of services that a client is liable to pay. A sliding fee scale based on income and family size is used for the SPED and Expanded SPED programs.

Homemaker

Homemaker is a service that provides assistance to persons that have an intermittent or occasional need for minor routine assistance with general light housework, laundry, or meal preparation. This service uses a unit rate for billing (unit equals 15 minutes) and is covered under both the SPED and Expanded SPED programs.

Instrumental Activity of Daily Living (IADL)

IADLs are those measurable activities that may not need to be done daily, but are important for independent living. They are used in determining SPED and Expanded SPED eligibility. IADLs include the following:

- Meal preparation
- Housework
- Laundry
- Shopping
- Taking medicine

- Ability to get around outside the person's home
- Transportation
- Money management
- Use of a telephone

Medicaid Waiver

The Medicaid Waiver program is a home and community-based services federal waiver program that enables states to deliver, under waiver of several Medicaid requirements, services to the aged and disabled at risk of institutionalization.

Non-Medical Transportation

Non-medical transportation is a service that enables clients to access essential community resources/services needed in order to maintain themselves in a home and community setting. Essential community resources/services are basic necessities needed in order to live in the community rather than a nursing home, including the grocery store, utility company, Social Security Office, and the post office. For billing, this service uses a number of different billing rates dependent upon the service being provided. This service is covered under both SPED and Expanded SPED.

Personal Care

Personal care is a service that provides clients with daily care, such as bathing, dressing, transferring, toileting, and supervision. For billing, this service uses either a daily rate or a unit rate (unit equals 15 minutes) and is covered under both the SPED and Expanded SPED programs.

Qualified Service Provider (QSP)

A QSP is a county social service board or independent contractor who agrees to meet certain standards for service and operations. QSPs are enrolled by the Aging Services Division and a QSP may be an individual or an agency.

Respite Care

Respite care is a service that provides temporary relief to the client's primary caregiver from the stresses and demands associated with daily care or emergencies. For billing, this service uses either a daily rate or a unit rate (unit equals 15 minutes) and is covered under both the SPED and Expanded SPED programs.

Service Payments for the Elderly and Disabled (SPED)

SPED provides payments for in-home and community-based services to functionally impaired older individuals and persons with physical disabilities who need the assistance of another person to continue to live in a home or community setting. The program functions as an alternative to nursing home care. Services are provided by Qualified Service Providers who are enrolled by the Department of Human Services.

List of Recommendations

Recommendation 2-1 We recommend the Aging Services Division implement controls to ensure that authorized amounts for services to clients are not exceeded by the Qualified Service Providers.

Recommendation 2-2 We recommend the Department of Human Services implement additional controls to monitor duplicate payments on MMIS.

Recommendation 2-3 We recommend the Aging Services Division implement controls to ensure that individual Qualified Service Providers do not provide more than 200 hours of service in a month unless an emergency or unusual circumstance exists.

Recommendation 2-4 We recommend the Aging Services Division implement additional monitoring procedures and management controls for the SPED and Expanded SPED programs. At a minimum, the division should:

a) Ensure SPED funds are not used for eligible Medicaid Waiver expenses;
b) Ensure program funds are spent for services actually provided;
c) Increase consistency in establishing the authorized units of service to be provided to clients; and
d) Increase compliance with completing the monthly rate worksheet.

Recommendation 2-5 We recommend the Department of Human Services review controls in MMIS and take the appropriate actions to ensure that SPED and Expanded SPED claims are processed correctly and efficiently.

Recommendation 2-6 We recommend the Aging Services Division:

a) Better communicate the requirements of provider log documentation and records retention requirements to the Qualified Service Providers; and
b) Monitor the Qualified Service Provider logs to ensure provider log requirements are complied with.

Recommendation 3-1 We recommend the Aging Services Division provide additional guidance for case management by developing and implementing policies and procedures that, at a minimum:

a) Define case management and identify what can and can not be billed;
b) Define administrative tasks; and
c) Identify case management documentation requirements.

Recommendation 3-2 We recommend the Aging Services Division provide additional training to the counties in the case management area. This may require training to be tailored to specific counties and/or individual case manager needs.

Recommendation 3-3 We recommend the Aging Services Division monitor case management billings by:

a) Periodically performing analytical reviews of case management billing data; and

b) Comparing case management billings to case file documentation.

Recommendation 3-4 We recommend the Aging Services Division make changes to the rate setting process for case management. At a minimum, the division should:

a) Consider setting the case management rates based on costs or a percentage of program funding;
b) Have adequate documentation for justifying the rate setting process for case management; and
c) Ensure periodic review of the case management rates.

Recommendation 4-1 We recommend the Aging Services Division implement procedures and establish controls related to clients' self declarations of income and assets.

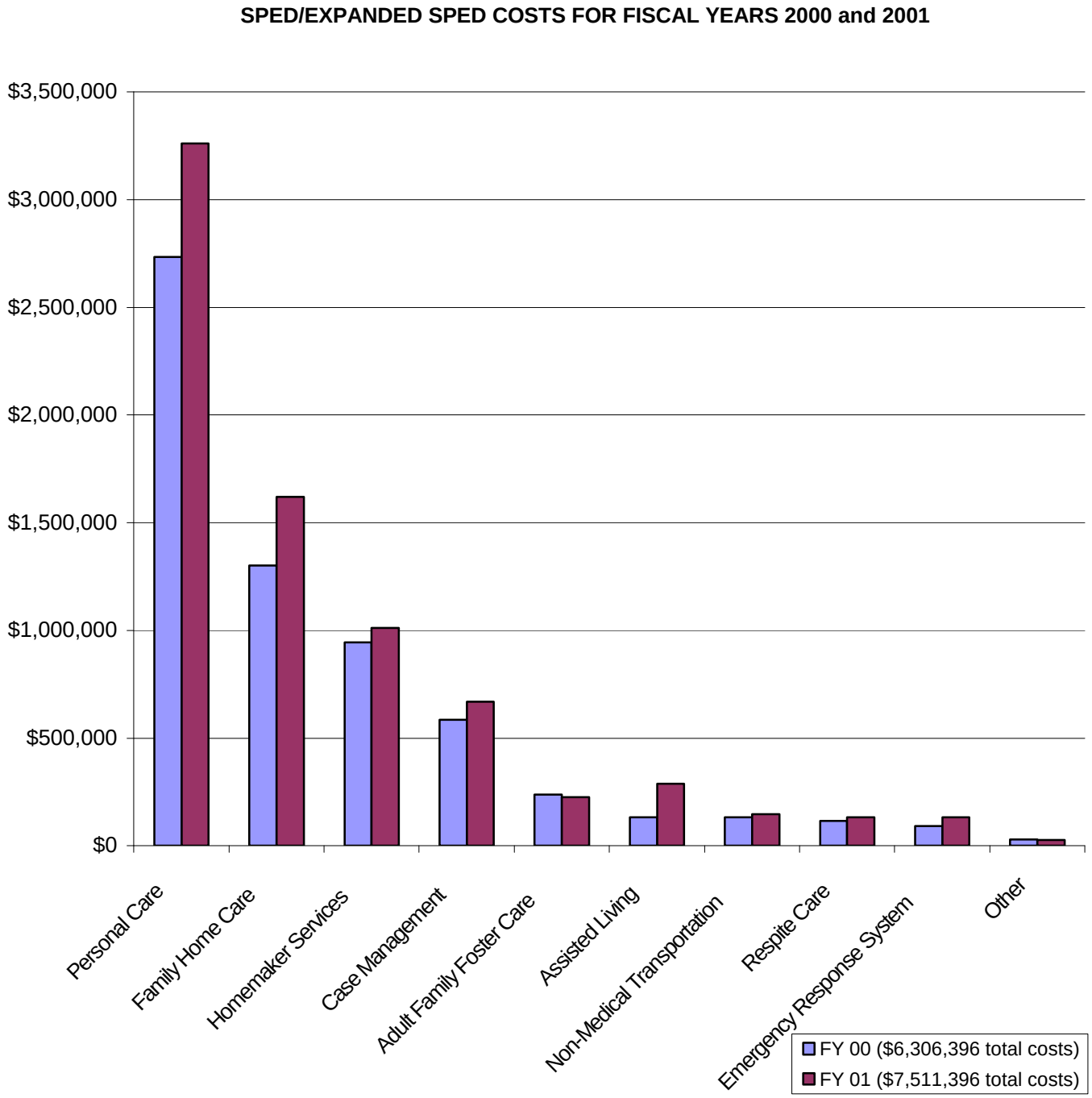
Recommendation 4-2 We recommend the Aging Services Division make improvements to the screening requirements and processes used to enroll applicants as Qualified Service Providers.

Recommendation 4-3 We recommend the Aging Services Division, in conjunction with appropriate legal counsel, review laws, rules, and policies related to denying applicants applying for Qualified Service Provider status and determine appropriate changes to provide additional authority to deny such applicants. The division should:

a) Take appropriate action to make necessary changes to laws, rules, and policies; or
b) Document the decision as to why such changes are not necessary.

SPED and Expanded SPED Program Expenditures

The graph below identifies SPED and Expanded SPED expenditures by type of service delivered. This information was obtained from the Department of Human Services and was processed through the Medicaid Management Information System (MMIS). Information was readily available for fiscal years 2000 and 2001 but not for fiscal year 1999. Differences in the total amounts in the graph below and financial information reported in Chapter 1 are due to year end adjustments and are not considered significant.



Client Eligibility Requirements and Process

The following flowchart identifies the process and eligibility criteria for an individual to be a client of the Medicaid Waiver, SPED, and Expanded SPED programs.